STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043022	A. BUILDING: _____ B. WING _____	R 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINECREST GARDENS	1984 OLD US 421 LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 01/23/25 - 01/24/25.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including personal care products and two boxes of double blade disposable razors that were accessible to the residents diagnosed with dementia who lived on the back hall unit of the facility. The findings are: Review of the facility's census report received on 01/23/25 revealed: -There was a total of 54 residents residing in the facility. -There were 10 residents who lived on the back hall unit of the facility. Interview with the facility's Manager on 01/23/25 at 1:20pm revealed the facility did not have a written policy for the storage of personal care products on the back hall unit.	D 079		

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D 079	Continued From page 1 Observation of the only common bathroom in the back hall unit on 01/23/25 at 10:38am revealed: -The door to the bathroom was open and accessible to residents. -There was a wooden storage organizer with 4 shelves that had multiple personal care hygiene products on the top shelf including shampoos, conditioners, body wash, antiperspirants, deodorants, hand and body lotion, shaving creams, hairspray, toothpastes, and petroleum jelly. -There were three cans of shaving cream, petroleum jelly, and an unlabeled, unidentified, greenish blue liquid in a plastic gallon milk jug on the bottom shelf of the organizer. -There was cocoa butter lotion and conditioner on the shelves in the shower stall. -There were two containers of corn starch baby powder on the counter near the sink on the left. -Warning labels on the products included for external use only; keep out of eyes; keep out of reach of children; avoid inhalation which could cause breathing problems; deliberately concentrating and inhaling vapor contents can be harmful or fatal; extremely flammable; and in case of ingestion get medical help right away or contact a poison control center (PCC) right away. -There were no residents or staff in the common bathroom. Interview with the facility's Manager on 01/23/25 at 11:14am revealed: -All the residents who resided on the back hall unit had dementia. -There were at least two residents who lived on the back hall unit that had wandering behaviors. -The personal care products for residents residing on the back hall unit should be stored and locked in the linen closet near the common	D 079		

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D 079	Continued From page 2	D 079		

bathroom.
-There was a key kept on the medication cart so staff could access the linen closet when the personal care products were needed.
-She was concerned that the personal care products had been left out in the common bathroom on the back hall unit because the residents with dementia could get confused and try to ingest the products or they could accidentally rub personal care products in their eyes.
-There was no system to check or monitor the personal care products in the back hall unit because she thought staff knew they were supposed to keep the personal care products locked up.

Interview with a personal care aide (PCA) working on the back hall unit on 01/23/25 at 3:17pm revealed:
-They usually kept the personal care products in the common bathroom on the back hall unit on the shelves of the wooden organizer because it was convenient for staff when bathing residents to have the products close by so staff did not have to leave the residents unattended to retrieve the products.
-Staff could supervise the residents easier if the products were kept in the bathroom.
-She had not been instructed by anyone to lock the personal care products in the linen closet.
-She was not aware of any residents trying to ingest any personal care products.
-There was one resident on the back hall unit that used the bathroom independently and did not have staff supervision while in the bathroom.
-The other residents required staff assistance in the bathroom.

Second observation of the common bathroom in

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D 079	Continued From page 3	D 079		

the back hall unit on 01/23/25 at 3:29pm revealed:
-There were still three cans of shaving cream, petroleum jelly, and an unlabeled, unidentified, greenish blue liquid in a plastic gallon milk jug on the bottom shelf of the organizer.
-There were two boxes of double blade disposable razors on the third shelf of the organizer.

Second interview with a PCA working on the back hall unit on 01/23/25 at 3:29pm revealed:
-The greenish blue liquid in the unlabeled gallon milk jug on the bottom shelf of the storage organizer was body soap the facility had received in large quantities during the holiday season.
-She had not noticed the razor blades, shaving cream, or petroleum jelly were on the shelves of the organizer.

Interview with the Resident Care Coordinator (RCC) on 01/23/25 at 4:16pm revealed:
-There was no written policy for the storage of personal care products on the back hall unit prior to today, 01/23/25.
-She expected staff to put personal care products in the linen closet after use and lock the linen closet.
-There was no system to check behind staff to ensure personal care products were being stored in the locked linen closet.
-There were at least two residents who resided in the back hall unit that had wandering behaviors.
-No one had ingested or gotten any personal care products in their eyes.

Third observation of the common bathroom on the back hall unit on 01/24/25 at 10:14am revealed:
-A plastic storage container with an unopened lid

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D 079	Continued From page 4 containing deodorant and cream was sitting on the sink countertop. -There was shaving cream, baby powder, and lotion sitting on the sink countertop. -There were no residents or staff in the bathroom. Interview with the facility's Manager on 01/24/25 at 4:20pm revealed: -The personal care products, including the disposable razors, should not have been left unlocked and unattended in the common bathroom on the back hall unit. -She thought a hospice aide may have left the personal care products in the bathroom after bathing a resident that morning, 01/24/25. -She contacted the hospice agency today, 01/24/25 to let them know the facility's policy was to keep the personal care products on the back hall locked in the linen closet.	D 079		